DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2003-04**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.130

7. FEDERAL BUDGET IMPACT:
a. FFY **2003** **$ (8.4M)**
b. FFY **2004** **$ (8.4M)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 71
Attachment 3.1-A, Exhibit 13c, Page 2
Attachment 3.1-A, Pages 3, 4, and 5
Attachment 4.19-B, Page 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page 71
Attachment 3.1-A, Exhibit 13c, Page 2
NEW
Attachment 4.19-B, Page 13

10. SUBJECT OF AMENDMENT: **This State Plan Amendment authorizes the Division of Medicaid to develop and implement disease management programs.**

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Rica Lewis-Payton**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: **January 28, 2003**

16. RETURN TO:
Rica Lewis-Payton, Executive Director
Miss. Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

(Revised 6-27-03)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
January 29, 2003

18. DATE APPROVED
July 25, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Rhonda K. Cartwell

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

State/Territory: Mississippi

Citation 4.23 Use of Contracts

42 CFR Part 434
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

/ / Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

___ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

_X_ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

___ Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.c. Preventive Services - Disease Management

The State of Mississippi will provide a statewide Disease Management Program to Medicaid beneficiaries eligible for Title XIX Medicaid coverage under the Categorically Needy Program (CNP), who receive services through the Medical Assistance Administration's (MAA) fee-for-service system, and who have one or more of the following diseases:

- Asthma;
- Diabetes;
- Hypertension.

Individuals Eligible for Services

Target Group: The target group of Medicaid beneficiaries to receive Disease Management services are beneficiaries who:

- Receive medical services through fee-for-service coverage;
- Are not already receiving care coordination services as residents of an institution, participants in a Medicaid waiver program, or enrollees in a hospice program;
- Have a diagnosis of asthma, diabetes, or hypertension, are of sufficient age and cognitive ability to actively respond to health information and care coordination activities, and do not already have a catastrophic condition that takes precedence over the beneficiary's asthma, diabetes, or hypertension.

Components of Disease Management

The contracted disease management organization will provide the following services to beneficiaries eligible for the program:

- Initial health assessment by a registered nurse, licensed in the State of Mississippi, and periodic follow-up of the ongoing health status of enrolled beneficiaries. The assessment process includes the development and implementation of an individual plan of care that addresses the beneficiaries' multiple health, behavioral and social needs, and that ensures continuity, quality and effectiveness of care in consultation with the individual's physician. In addition, the nurse will: provide the beneficiary with health information related to patient self management skills, patient self-administration of medications, and crisis health care management; evaluate a beneficiary's health condition and make short-

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term medical recommendations subject to a physician's final approval; and assist the physician with implementation of the physician's care plan for the patient.

- When necessary, assist in accessing appropriate primary and preventive medical care; care coordination: referrals for specialty, social and ancillary services; and promotion of self-management. These activities will take place through use of a nurse consultation telephone line in which nurses may initiate monitoring and follow-up calls to beneficiaries in the program, as well as to provide twenty-four (24) hour seven (7) days per week access to nurse consultation for beneficiary-related calls about their treatment plan and self management and management of medical crises. Additionally, field visits by a nurse will be made to beneficiaries when appropriate.

Choice of Providers

The State assures that there will be no restrictions on a beneficiary's freedom of choice of providers in violation of Section 1902(a)(23) of the Act. Eligible clients have free choice to receive or not receive disease management services through the contracted Disease Management Organization (DMO) and may change case managers within the DMO at any time. Eligible beneficiaries also have free choice of the providers of other medical care under the program.

Criteria for Disease Management Providers

a. All Disease Management case managers shall be registered nurses and/or licensed social workers who meet the requirements of the contracted disease management organization.

   All case management nurses and/or social workers shall be licensed in the State of Mississippi. Additional services may be provided by disease-specific educators licensed, credentialed or specifically trained to practice in the State of Mississippi.

b. The State will contract through a bidding process with the disease management organization that best meets the program requirements.

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c. The disease management provider that contracts with the Division of Medicaid to provide disease management services must meet the following conditions:

(1) Has not been sanctioned by a State or federal government within the last 10 years;
(2) Has a minimum of three years' experience providing disease management services;
(3) Maintains a computer system sufficient to carry out all of the required components of the disease management contract;
(4) Has an evidenced-based healthcare practice guideline for specific disease state being managed;
(5) Has an established collaborative healthcare practice model to include DOM's current providers, community-based partners including, but not limited to, faith based organizations, school nursing programs and other support-service providers.
(6) Has patient self-care management educational materials and methods appropriate to each targeted disease population;
(7) Has internal quality assurance/improvement, outcomes measurement, evaluation and management systems;
(8) Has demonstrable and successful experience in disease management for the targeted disease populations;
(9) Provides access to a call center 24-hour-a-day, seven-day-per-week with licensed medical personnel who have training and/or are credentialed in the disease specific area. All staff must be trained in at least the areas of establishing rapport, cultural sensitivity, and stages of change. The helpline must also be equipped with appropriate technology to accept calls from all members, ensuring program responsiveness and access to all services for people with limited English proficiency;
(10) Has the ability to guarantee program savings;
(11) Meets applicable federal and state laws and regulations governing the participation of providers and beneficiaries in the Medicaid program.

Comparability of Services

All beneficiaries eligible to participate in the disease management program will receive comparable services, based on their level of disease and co-morbid conditions. All beneficiaries will be assessed for their risk level and will receive follow-up education and disease management services.

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Enrollment/Disenrollment Process

This disease management program is a voluntary program. While all eligible beneficiaries will be automatically enrolled in the Disease Management Program, any beneficiary may disenroll through the following methods:

(a) Beneficiaries may request disenrollment at the end of any month by calling the contracted Disease Management Organization with whom the beneficiary is enrolled. This process is referred to as "opting out"of the Disease Management Program;
(b) The contracted disease management organization may recommend disenrollment to the Division of Medicaid through an approved process;
(c) Division of Medicaid may disenroll due to eligibility change.

Beneficiaries may also re-enroll or "opt-in" the Disease Management Program at any time by calling the contracted disease management organization.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services: Other services described in Attachment 3.1-A, Exhibit 13 are reimbursed according to a statewide uniform fixed fee schedule established through consultation with the State Department of Mental Health. EPSDT will reimburse $85.00 for psychological evaluations.

Mental health services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

Other diagnostic screening, preventive and rehabilitative services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed on a fee schedule.

Preventive Services - Disease Management: Disease Management contractors will be paid utilizing a prepayment methodology that is in compliance with 42 CFR 438.6(c). Capitation payments will be made monthly. Capitation rates will vary according to the specific disease state group.

Payment Methodology for the Program

The State will use a per member per month method of payment for the contracted Disease Management program. The State expects at least a five percent guaranteed minimum of net savings. The guaranteed savings is defined as the savings in excess of the expense (expressed as a percentage of the base medical claims, Division of Medicaid established baseline for the disease specific population) of the Disease Management services for that population. If the amount of guaranteed minimum net savings is not achieved for the period specified, the difference between the guaranteed minimum net savings and the actual net savings will be paid by the Contractor to the Division of Medicaid. Under this method, payment will not exceed the amount the State would have paid had disease management services not been provided.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. This provision is not applicable to Disease Management Services.